

may be retained by the hospital or attending physician. in by the funeral director, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11142

11131

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Ballard Last Ballard		4. DATE OF DEATH Month 10 Day 4 Year 1957	
5. SEX Fe	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-87
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Charles Haskins		14. MOTHER'S MAIDEN NAME Isabelle Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Samuel E. Greene (Cousin)	
17. INFORMANT Address Belleve, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cerebrovascular DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2-3 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cachexia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9-12-1957 to 10-4-1957 , that I last saw the deceased alive on 10-4-1957 , and that death occurred at 1:39 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Guym Reeser M.D.		ADDRESS (Street, city or town, state) St Michaels Md	
PHYSICIAN'S NAME (Type) Guym Reeser		DATE SIGNED 10-4-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/6/57	22c. NAME OF CEMETERY OR CREMATORY Hammocktown	22d. LOCATION (City, town, or county) (State) Easton Md
23. FUNERAL DIRECTOR'S SIGNATURE James B. Washfield ADDRESS		24a. REC'D BY REGISTRAR 10/6/57	24b. REGISTRAR'S SIGNATURE N. A. Nevins

CERTIFICATE OF DEATH

1181

BUREAU V. 8

OCT 11 1957

RECEIVED

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF BIRTH [Faint handwritten date]		PLACE OF BIRTH [Faint handwritten place]		RACE [Faint handwritten race]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]		TIME OF DEATH [Faint handwritten time]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF DECEASED [Faint handwritten signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11143

11154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman	
c. LENGTH OF STAY IN 1b 8 years		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle R. Last BRITTON		4. DATE OF DEATH Month October Day 6 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1896
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Morgan		14. MOTHER'S MAIDEN NAME Caroline Horney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles G. Britton, Wittman, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) arteriosclerotic cardiovascular DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) uremia - 6 mos. Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-9-1953 to 10-6-1957 , that I last saw the deceased alive on 10-6-1957 , and that death occurred at 7:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels Md DATE SIGNED 10-2-57			
ACTUAL SIGNATURE Wm M. Reeser Jr M.D. St. Michaels Md		PHYSICIAN'S NAME (Type) Wm M. Reeser Jr	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Tilghman Cemetery		22d. LOCATION (City, town, or county) (State) Tilghman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hamilton Harrison Sr. Michael		24a. REC'D BY REGISTRAR DATE OCT 11 '57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Reeser	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

See Note on

Name of Deceased		Robert L. Morgan	
Date of Death		October 11, 1957	
Place of Death		Baltimore, Maryland	
Age		41	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		None	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Physician		Charles G. Morgan	
Signature of Registrar		Caroline Morgan	

BUREAU Y. S.

OCT 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11155
CERTIFICATE OF DEATH

11144
290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton Rt. 4				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Joan Last Brummell				4. DATE OF DEATH Month 10 Day 14 Year 1957			
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/33	9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Randall Thomas Jr.				14. MOTHER'S MAIDEN NAME Nannie Moaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Brummell , Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.1 carcinoma - severe DUE TO sarcoma - abdominal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 mos. (c) 5 mos.						INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sarcoma Generalized - Metastatic						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-22-57 to 10-15-57 , that I last saw the deceased alive on 10-15-57 , and that death occurred at 6 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gay M. Reeser				ADDRESS (Street, city or town, state) DATE SIGNED St Michaels Md 10-18-57			
PHYSICIAN'S NAME (Type) Gay M Reeser							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/57		22c. NAME OF CEMETERY OR CREMATORY Royal Oak		22d. LOCATION (City, town, or county) (State) Easton, Rt. 4 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.			
24a. REC'D BY REGISTRAR OCT 23 1957				24b. REGISTRAR'S SIGNATURE Mrs. N. H. Newmyer			

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OCT 23 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11156

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels			c. LENGTH OF STAY IN 1b 4 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last BUCHANAN				4. DATE OF DEATH Month October Day 27 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Elevator operator				10b. KIND OF BUSINESS OR INDUSTRY Elevator operator		11. BIRTHPLACE (State or foreign country) Carroll Co. Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Christian Bachman				14. MOTHER'S MAIDEN NAME Barbara Elizabeth Dietz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Robert L. Wilson Address St. Michaels, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular DUE TO (c) also - cachexia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) adenocarcinoma of prostate - metastases							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-20-57 to 10-27-57 , that I last saw the deceased alive on 10-27-57 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) St Michaels Md DATE SIGNED 10-27-57							
ACTUAL SIGNATURE Guy M. Peever M.D.							
PHYSICIAN'S NAME (Type) Guy M Peever							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Pl.				24a. REC'D BY REGISTRAR DCT 29 57		24b. REGISTRAR'S SIGNATURE	

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OCT 29 1957

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11146

11132

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 N. Aurora St.				d. STREET ADDRESS 17 N. Aurora			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROY Middle D. Last FLECKENSTEIN				4. DATE OF DEATH Month October Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 10, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Owned Mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Leonard S. Fleckenstein				14. MOTHER'S MAIDEN NAME Adeline Kauffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-07-5067A		17. INFORMANT Address Mrs. Hortense Fleckenstein Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 34 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUNE , 19 53 , to OCT. 5 , 19 57 , that I last saw the deceased alive on OCT. 5 , 19 57 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley M.D.				ADDRESS (Street, city or town, state) 97 N. Hanson St. Easton, Md.			
DATE SIGNED 10-7-57							
PHYSICIAN'S NAME (Type) Dr. Donald F. Bartley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 10/8/57	
				24b. REGISTRAR'S SIGNATURE N. H. Newnam			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11147

Reg. Dist. No. 290

11133

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> <u>05x0.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>P.O.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Frazier</u> Last <u>Frazier</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>B.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 12, 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Chase</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Webb</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-2327</u>		17. INFORMANT <u>Eleanor Edmonds</u> Address <u>(Niece)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the ovary</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>142</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>22 Oct</u> , 19 <u>57</u> , to <u>25 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>57</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Maryland 29001</u> DATE SIGNED <u>29 Oct 57</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON EASTON, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>near Preston md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son</u> ADDRESS <u>Federalburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newkirk</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	

1

M

11157

11148

Reg. Dist. No. 290

11157

CERTIFICATE OF DEATH

11148

Reg. Dist. No. 290

1

M

11157

11148

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - TRAPPE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - TRAPPE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "WINDY HILL"				d. STREET ADDRESS "WINDY HILL"			
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE O'DELLA HELFRICH				4. DATE OF DEATH Month Day Year OCT. 5 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 2, 1878		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ASA COVEY				14. MOTHER'S MAIDEN NAME ELIZABETH BLADES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address MR. WILLIAM HELFRICH, TRAPPE, R.D. MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 57 , to Oct. 5 , 19 57 , that I last saw the deceased alive on Oct. 5 , 19 57 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley M.D.				ADDRESS (Street, city or town, state) 9 N. Hanson St. Easton, Md. DATE SIGNED 10-7-57			
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/9/57		22c. NAME OF CEMETERY OR CREMATORY SPRING HILL		22d. LOCATION (City, town, or county) (State) EASTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Thompson				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR 10/9/57 24b. REGISTRAR'S SIGNATURE N. A. Newell	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
HARRIS		38		M		W		1957		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
100 N. ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		OCT 11 1957		BOSTON	
FATHER		MOTHER		SPOUSE		CHILDREN		DATE OF BIRTH		PLACE OF BIRTH	
J. HARRIS		M. HARRIS		J. HARRIS		J. HARRIS		1919		MASSACHUSETTS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
OCT 11 1957		BOSTON		HEART DISEASE		NATURAL		OCT 11 1957		BOSTON	
FATHER		MOTHER		SPOUSE		CHILDREN		DATE OF BIRTH		PLACE OF BIRTH	
J. HARRIS		M. HARRIS		J. HARRIS		J. HARRIS		1919		MASSACHUSETTS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
OCT 11 1957		BOSTON		HEART DISEASE		NATURAL		OCT 11 1957		BOSTON	
FATHER		MOTHER		SPOUSE		CHILDREN		DATE OF BIRTH		PLACE OF BIRTH	
J. HARRIS		M. HARRIS		J. HARRIS		J. HARRIS		1919		MASSACHUSETTS	

BUREAU V. 1

OCT 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11134

CERTIFICATE OF DEATH

11142

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs. 50 min</u>		d. STREET ADDRESS <u>17x0.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Albert</u> Last <u>Horner</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Horner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pritchett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Gillian B. Potts (Sister)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephrosis</u> <u>601x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dementia</u> (c) <u>Nodular hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , and that death occurred at <u>2:45 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington</u> DATE SIGNED <u>14 Oct 57</u> ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washell</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>10/15/57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

RECEIVED
OCT 21 1957
BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11135 CERTIFICATE OF DEATH

11150

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> <u>05 x 0.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dawson Allen Hubbard</u>				4. DATE OF DEATH Month Day Year <u>10 - 4 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-4-1946</u>	
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child = School Boy</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Dawson George Hubbard</u>				14. MOTHER'S MAIDEN NAME <u>Alice Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Dawson George Hubbard Denton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Diffuse Peritonitis</u> <u>550.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gangrenous Appendicitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-2-</u> _____, 19 <u>57</u> , to <u>10-4-</u> _____, 19 <u>57</u> , that I last saw the deceased alive on <u>10-4-1957</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		M.D. <u>2495 W 24th St 40157</u>		ADDRESS (Street, city or town, state) <u>Easton, 10, Maryland</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Concord</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Hampton Son</u>				ADDRESS <u>Federalburg Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Newkirk</u>			

MASTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED
OCT 11 1957
BUREAU V. 1

OCT 11 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11136

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11151

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 S. Washington St.		d. STREET ADDRESS Bruceville (nr Trappe) X 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERMAN Middle C. Last KAMMKE		4. DATE OF DEATH Month Oct. Day 5, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gus Kammke		14. MOTHER'S MAIDEN NAME Augusta Bewick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.I		16. SOCIAL SECURITY NO. 215-07-4591	
17. INFORMANT Mrs. Herman C. Kammke		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) formed (c) 420.1 DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Oct 5 1957 Hour 6:30 o. m. P.M.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Louis Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Louis E. Welty		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-6-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Trappe, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR 10/8/57		24b. REGISTRAR'S SIGNATURE N. A. Newnam	

MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SEE THIS SIDE

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX AT DEATH

RACE AT DEATH

BUREAU V. 11

OCT 11 1957

RECEIVED

11137

CERTIFICATE OF DEATH

Reg. Dist. No. 290 253

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>EASTON</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>		OR TOWN <u>17x0.2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WALTER STEPHEN KELLEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 23 19 57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>APRIL 10-1907</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS M. KELLEY</u>				14. MOTHER'S MAIDEN NAME <u>ADDIE THOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>213-14-6736</u>		17. INFORMANT & ADDRESS <u>MRS. WALTER KELLEY / CHESTER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Oct. 23, 1957</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>angina pectoris</u>						<u>about 3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>hypertensive cardio-vascular disease</u>						<u>3 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis general</u>						<u>3 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>May 10, 1954</u> , to <u>Oct. 23, 1957</u> , that I last saw the deceased alive on <u>Oct. 23, 1957</u> , and that death occurred at <u>420 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Theodor Sattelmayer</u>		M.D. <u>Stevensville Md.</u>		ADDRESS (Street, city, town, state) <u>Stevensville Md.</u>		DATE SIGNED <u>Oct. 24, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct. 26</u>	NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		LOCATION (City, town, or county) (State) <u>Stevensville Ind.</u>			
24. REC'D BY REGISTRAR <u>Oct 26, 1957</u>	REGISTRAR'S SIGNATURE <u>Elizabeth Hester</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Lane Church Hill, Ind.</u>		ADDRESS <u>Mrs. T. H. Houser</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11138

CERTIFICATE OF DEATH

11153

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN b 2 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Talbot		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 710 South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Alice Catherine Kramer		4. DATE OF DEATH Month Day Year October 21, 1957		5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-1889		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 2 0 0 0		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Fuchs		14. MOTHER'S MAIDEN NAME Elizabeth Halssimer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none		17. INFORMANT Gustav Kramer Address Easton, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Hour o. m. Month, Day, Year 2 p.m. 10-21-19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		ACTUAL SIGNATURE Louis M. DME M.D.		ADDRESS (Street, city or town, state) Easton Md		DATE SIGNED 10-21-57		PHYSICIAN'S NAME (Type) INELTV		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-57		22c. NAME OF CEMETERY OR CREMATORY Jr. Order U.A.M.		22d. LOCATION (City, town, or county) (State) Preston, Md.		23. FUNERAL DIRECTOR'S SIGNATURE J. M. Hecchi ADDRESS Preston		24a. REC'D BY REGISTRAR DATE 10/21/57		24b. REGISTRAR'S SIGNATURE N. H. Thomas	

CERTIFICATE OF DEATH

OCT 23 1957

BUREAU V. 3

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11139

CERTIFICATE OF DEATH

11154

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>14 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> <u>17X0-2</u>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>W</u> Middle <u>Samuel</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-8-1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water man</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Mr. Samuel E. Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Mannie Bell Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. William R. Marshall, 2814 Eldarue Drive, Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis left hemiplegia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-18</u> , 19 <u>57</u> , to <u>1961</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>18 Oct</u> , 19 <u>57</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thorston Harrison</u>				ADDRESS (Street, city or town, state) <u>Chester, Queen Anne's</u>		DATE SIGNED <u>1961-10-17</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane, Jr.</u>				ADDRESS <u>Laurel Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>W. H. Newell</u> DATE <u>10/21/57</u>	
						24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11140

CERTIFICATE OF DEATH

11155
290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Coroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>5 1/2 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Federalsburg 05x0.2</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Meredith</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Hignutt</u>				14. MOTHER'S MAIDEN NAME <u>Emma Breeding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr Norman Meredith (husb)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, operative</u> <u>154X</u> DUE TO Obesity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obesity</u> (c) <u>Obesity</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of rectum</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. 110457</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Wilkerson</u>				ADDRESS <u>Federalsburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/17/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. D. Newlin</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARY ANN		65		F		W		1892		BALTIMORE		MD		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
OCT 21 1957		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		10 DAYS		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CHURCH		SIGNATURE OF OTHER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 21 1957

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may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11156

11158

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ----				d. STREET ADDRESS 1 -----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CLARENCE Middle HAROLD Last MILAN				4. DATE OF DEATH Month October Day 9 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1884	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Teller				10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Michel Milan				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 131-03-4937		17. INFORMANT Mrs. W. S. Milan, Baston, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 years 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 1956 to 9 October 1957 , that I last saw the deceased alive on 8 October 1957 , and that death occurred at 1:05 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Lane Wright M.D.				ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md. 20685			
DATE SIGNED Oct 11 1957							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison, St. Michaels Md.				24a. REC'D BY REGISTRAR Oct 11 1957		24b. REGISTRAR'S SIGNATURE Paul	

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1957 11 OCT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with
the necessary information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11142

CERTIFICATE OF DEATH

11159

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Calbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> 05X0-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>05X0-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Elizabeth Morgan</u>		4. DATE OF DEATH Month Day Year <u>10 31 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr Thomas Neal</u>		14. MOTHER'S MAIDEN NAME <u>Marina Higman Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ms Floyd Morgan</u>		Address <u>Ridgely, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> <u>420.0</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cerebrovascular HT Dis</u> (c) <u>Stroke Cerebrals</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>4 weeks</u> <u>5 years (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/30</u> , 19 <u>57</u> , to <u>10/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>57</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. WIMACOTT</u> M.D.		ADDRESS (Street, city or town, state) <u>Ridgely, Md</u> DATE SIGNED <u>11-4-57</u>	
PHYSICIAN'S NAME (Type) <u>C. WIMACOTT</u>		<u>Ridgely, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 4 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brentwood</u>	22d. LOCATION (City, town, or county) (State) <u>Brentwood Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>11/4/57</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Neeris</u>	

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11143

CERTIFICATE OF DEATH

11158

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>1508 So. Guroora St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>C.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/99</u>
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Used Cars</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Miller</u>		14. MOTHER'S MAIDEN NAME <u>Sadie R. Carlyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Margaret Miller (Wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Apoplexy</u> (c) <u>H. C. V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/26/57</u> to <u>10/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/26</u> , 19 <u>57</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. E. Coff</u>		M.D. <u>Easton Md</u> DATE SIGNED <u>10/28/57</u>	
PHYSICIAN'S NAME (Type) <u>P. E. Coff</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 29, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Newman</u>		ADDRESS <u>5501 Easton, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>10/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newen</u>	

BUREAU V. S.

NOV 5 1957

RECEIVED

12352

CERTIFICATE OF DEATH

Reg. Dist. No. 290

11144

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 25 min</u> <u>xo Cordova</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Monroe</u> Last <u>Monroe</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cal</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 19, 1957</u>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Clinton Baker</u>				14. MOTHER'S MAIDEN NAME <u>Rosalee Monroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mother (Rosalee Monroe)</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 25 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/19</u> , 19 <u>57</u> , to <u>10/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>57</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kurt Lederer</u>				ADDRESS (Street, city or town, state) <u>Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>				DATE SIGNED <u>11/11/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incineration</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital</u>				24a. REC'D BY REGISTRAR <u>DATE 10/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2080181XVO

15 1957

RECEIVED

11145

CERTIFICATE OF DEATH

Reg. Dist. No. 290

11160

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>4 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Marydel md 05x0.2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Margarette</u> Middle <u>Mueller</u> Last <u>Mueller</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/15/1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W. Jr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>gm Robert Boek Baet. md</u>				Address <u>2815 St Paul St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteriorly located Cardiac Vascular</u> <u>422.1</u> DUE TO <u>Swine</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/24</u> , 19 <u>57</u> , to <u>10/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Cox</u>				M.D. <u>Easton md</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 28</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cardova md</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond B. Rawlin</u>				ADDRESS <u>Greenbrook md</u>			
24a. REC'D BY REGISTRAR <u>18</u>				24b. REGISTRAR'S SIGNATURE <u>N. L. Newell</u>			
DATE <u>28/57</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF BURIAL PLACE	
15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY	
17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF	
21. SIGNATURE OF CONSTABLE		22. SIGNATURE OF DEPUTY CONSTABLE	
23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF FEDERAL CLERK	
27. SIGNATURE OF MARSHAL		28. SIGNATURE OF DEPUTY MARSHAL	
29. SIGNATURE OF JAILER		30. SIGNATURE OF DEPUTY JAILER	
31. SIGNATURE OF PRISON CLERK		32. SIGNATURE OF PRISON DEPUTY CLERK	
33. SIGNATURE OF PRISON WARDEN		34. SIGNATURE OF PRISON DEPUTY WARDEN	
35. SIGNATURE OF PRISON CHIEF CLERK		36. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
37. SIGNATURE OF PRISON CHIEF WARDEN		38. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
39. SIGNATURE OF PRISON CHIEF CLERK		40. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
41. SIGNATURE OF PRISON CHIEF WARDEN		42. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
43. SIGNATURE OF PRISON CHIEF CLERK		44. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
45. SIGNATURE OF PRISON CHIEF WARDEN		46. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
47. SIGNATURE OF PRISON CHIEF CLERK		48. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
49. SIGNATURE OF PRISON CHIEF WARDEN		50. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
51. SIGNATURE OF PRISON CHIEF CLERK		52. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
53. SIGNATURE OF PRISON CHIEF WARDEN		54. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
55. SIGNATURE OF PRISON CHIEF CLERK		56. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
57. SIGNATURE OF PRISON CHIEF WARDEN		58. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
59. SIGNATURE OF PRISON CHIEF CLERK		60. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
61. SIGNATURE OF PRISON CHIEF WARDEN		62. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
63. SIGNATURE OF PRISON CHIEF CLERK		64. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
65. SIGNATURE OF PRISON CHIEF WARDEN		66. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
67. SIGNATURE OF PRISON CHIEF CLERK		68. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
69. SIGNATURE OF PRISON CHIEF WARDEN		70. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
71. SIGNATURE OF PRISON CHIEF CLERK		72. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
73. SIGNATURE OF PRISON CHIEF WARDEN		74. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
75. SIGNATURE OF PRISON CHIEF CLERK		76. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
77. SIGNATURE OF PRISON CHIEF WARDEN		78. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
79. SIGNATURE OF PRISON CHIEF CLERK		80. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
81. SIGNATURE OF PRISON CHIEF WARDEN		82. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
83. SIGNATURE OF PRISON CHIEF CLERK		84. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
85. SIGNATURE OF PRISON CHIEF WARDEN		86. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
87. SIGNATURE OF PRISON CHIEF CLERK		88. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
89. SIGNATURE OF PRISON CHIEF WARDEN		90. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
91. SIGNATURE OF PRISON CHIEF CLERK		92. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
93. SIGNATURE OF PRISON CHIEF WARDEN		94. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
95. SIGNATURE OF PRISON CHIEF CLERK		96. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	
97. SIGNATURE OF PRISON CHIEF WARDEN		98. SIGNATURE OF PRISON CHIEF DEPUTY WARDEN	
99. SIGNATURE OF PRISON CHIEF CLERK		100. SIGNATURE OF PRISON CHIEF DEPUTY CLERK	

RECEIVED
NOV 5 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11146 CERTIFICATE OF DEATH

Reg. Dist. No. **290** 11161

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>3da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Durlock 05x0.2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ellwood</u> Middle <u>S</u> Last <u>Neal</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Eugene Neal</u>				14. MOTHER'S MAIDEN NAME <u>Devonia Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Myrtle N. Neal (wife)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443x</u> (b) <u>hypertensive Cardiovascular disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x pneumonia - chronic</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>57</u> , to <u>10/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Maryland 230049</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Durlock Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leith S. Hollingsby</u> ADDRESS <u>C. N. Market</u>				24a. REC'D BY REGISTRAR <u>10/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. D. Newell</u>	

BUREAU V. S.

OCT 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11159

CERTIFICATE OF DEATH

11162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McDaniel</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Oliver</u> Last <u>Palmer</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/7/1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Joseph Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Ann Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-18-4960</u>		17. INFORMANT <u>Katherine Palmer</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO <u> </u> (c) <u>Generalized Cerebrovascular</u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>4 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>30 June</u> , 19 <u>57</u> , to <u>10 - 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 October</u> , 19 <u>57</u> , and that death occurred at <u>10:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Russell Smith</u>				ADDRESS (Street, city or town, state) <u>Box 482 St. Michaels, Md.</u> DATE SIGNED <u>10-7-57</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>10/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clairborne, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Clairborne, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Normand Marshall</u> ADDRESS <u>St. Michaels</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>9 57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1912</i>		5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>CLERK</i>		7. MARITAL STATUS <i>MARRIED</i>		8. DATE OF DEATH <i>1957</i>		9. PLACE OF DEATH <i>HOSPITAL</i>		10. CAUSE OF DEATH <i>HEART DISEASE</i>		11. MANNER OF DEATH <i>NATURAL</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i>		17. NAME OF INTERMENT <i>JOHN J. SMITH</i>		18. DATE OF INTERMENT <i>1957</i>		19. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i>		20. NAME OF INTERMENT <i>JOHN J. SMITH</i>		21. DATE OF INTERMENT <i>1957</i>		22. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i>		23. NAME OF INTERMENT <i>JOHN J. SMITH</i>		24. DATE OF INTERMENT <i>1957</i>		25. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i>		26. NAME OF INTERMENT <i>JOHN J. SMITH</i>		27. DATE OF INTERMENT <i>1957</i>		28. PLACE OF INTERMENT <i>CATHOLIC CHURCH</i>		29. NAME OF INTERMENT <i>JOHN J. SMITH</i>		30. DATE OF INTERMENT <i>1957</i>	

BUREAU V. 1

NOT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11147

CERTIFICATE OF DEATH

11163
 Reg. Dist. No. 298

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN MADISON PARROTT</u>				4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/73</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTH PLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JAMES M. PARROTT</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>219-34-3975</u>		17. INFORMANT Address <u>Mr Charles E. Morris (Nephew)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarct</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6:10 P.M.</u> , 19 <u>10</u> , to <u>11:25 P.M.</u> , 19 <u>10</u> , that I last saw the deceased alive on <u>10</u> and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				DATE SIGNED <u>2193 Washington St. 2 Nov 57</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thurman E. Newman & Son</u>				ADDRESS <u>Easton</u>		24a. REC'D BY REGISTRAR <u>N.A. Neekis</u>	
				DATE <u>11/2/57</u>			

BUREAU V. S.

NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11164

11148

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston 05x0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Joseph Middle Planner Last Planner		4. DATE OF DEATH Month 10 Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 28, 1898
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-2047	
17. INFORMANT Mrs Lotte Planner (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 58% Acute hemabagic pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Oct , 19 57 , to 12 Oct , 19 57 , that I last saw the deceased alive on 12 Oct , 19 57 , and that death occurred at 4:50 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thurston Harrison M.D.		DATE SIGNED 16 Oct 57	
PHYSICIAN'S NAME (Type) THURSTON HARRISON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-16-57	
22c. NAME OF CEMETERY OR CREMATORY J. P. O'QUAM Cemetery		22d. LOCATION (City, town, or county) (State) Preston, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry M. Hollis		ADDRESS PRESTON, MD	
24a. REC'D BY REGISTRAR DATE 10/16/57		24b. REGISTRAR'S SIGNATURE N. H. Newkies	

RECEIVED

11160

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First NORA Middle WALKER Last SHURE				4. DATE OF DEATH Month Oct. Day 19, Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1868	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert F. Walker				14. MOTHER'S MAIDEN NAME Mary F. Edgell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Margaret Feree		Address Royal Oak, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cachexia - severe 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma - left breast - DUE TO (c) widely metastatic							INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-10-18 , to 10-19-57 , that I last saw the deceased alive on 10-19-57 , and that death occurred at 1:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stm Mich aels, Md. DATE SIGNED 10-19-57							
ACTUAL SIGNATURE [Signature]		M.D.					
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser		Stm Mich aels, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Oct. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR OCT 23 57	
				24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

1180

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. PLACE OF DEATH Baltimore, Maryland		12. DATE OF DEATH June 4, 1968		13. TIME OF DEATH 10:00 AM		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)		19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF REGISTRAR (None)	

BUREAU V. S.

OCT 23 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11166

11149

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>26 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Denton</u> 05x0.2			
3. NAME OF DECEASED (Type or print) <u>Ida</u> First <u>Snowberger</u> Middle <u>Snowberger</u> Last <u>Snowberger</u>				4. DATE OF DEATH <u>Oct. 15 1957</u> Month <u>Oct.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 21, 1877</u> 80 yrs.	
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Neighbors</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Becht</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>51,311,111</u>			
17. INFORMANT <u>Ma Olive Goodley</u> Address <u>513 Beechwood Wilmington, Del.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>21/5/57</u> to <u>23/5/57</u> , that I last saw the deceased alive on <u>23/5/57</u> , and that death occurred at <u>2:38 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				DATE SIGNED <u>2195.10.18/57</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Denton 16 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 18 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.V. Moore</u> ADDRESS <u>105</u>				24a. REC'D BY REGISTRAR DATE <u>10/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newick</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. MEDICAL HISTORY [Illegible]	
10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF DECEASED [Illegible]		12. SIGNATURE OF WITNESSES [Illegible]	
13. SIGNATURE OF REGISTRAR [Illegible]		14. SIGNATURE OF CLERK [Illegible]		15. SIGNATURE OF JURY [Illegible]	

BUREAU V. E.

OCT 21 1957

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11161

CERTIFICATE OF DEATH

11167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>✓</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>St. Michaels, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>O.</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Clara Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> Address <u>Mosela Wells - St. Michaels</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary</u> DUE TO (c) <u>heart d</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-10</u> , 19 <u>57</u> , to <u>10-10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-10</u> , 19 <u>57</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thy M. Reeser Jr</u> M.D. <u>St Michaels md</u> PHYSICIAN'S NAME (Type) <u>Thy M Reeser Jr</u> <u>10-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New St. Michaels</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Marshall</u> ADDRESS <u>St. Michaels</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 15 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

CERTIFICATE OF DEATH

MASS. REG. NO.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

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PLACE OF DEATH

BUREAU V. B.

OCT 15 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11162 CERTIFICATE OF DEATH

11168

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"WAVERLY"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILBUR</u> Last <u>TRADER</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 20, 1909</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN DAVIS TRADER</u>		14. MOTHER'S MAIDEN NAME <u>IDA MAE CHURCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>554-01-1218</u>	
17. INFORMANT <u>MRS. LILA G. TRADER</u>		Address <u>"WAVERLY" EASTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 1950, to _____, 1951, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, 1:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Chesapeake, Maryland</u> DATE SIGNED <u>20 Oct 57</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson</u>		24a. REC'D BY REGISTRAR DATE <u>10/7/57</u>	
ADDRESS <u>EASTON, MD</u>		24b. REGISTRAR'S SIGNATURE <u>W. N. Newlin</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11150 Item 16 Film Q222 10-29-57 et
CERTIFICATE OF DEATH

11169

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>ALBANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> 17x2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>L</u> Last <u>WILKINSON</u>		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service)		16. SOCIAL SECURITY NO. <u>213-03-7011D</u>	
17. INFORMANT <u>Mr Charles W. Coy, Chester Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic atherosclerotic heart disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 X</u> <u>diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>22 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 Oct</u> , 19 <u>57</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Chester, Maryland</u> DATE SIGNED <u>23 Oct 57</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 23, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice C. Harrison</u> ADDRESS <u>101 E. Easton Md.</u>		24. REC'D BY REGISTRAR DATE <u>10/25/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>N.H. Newkirk</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Block 100, No. 10

DECEASED'S NAME (Last, first, middle) LAST, FIRST, MIDDLE		SEX MALE FEMALE		AGE YEARS MONTHS DAYS		DATE OF BIRTH YEAR MONTH DAY		PLACE OF BIRTH CITY, STATE, COUNTRY		MARITAL STATUS SINGLE MARRIED WIDOW DIVORCED		OCCUPATION TRADE, PROFESSION, BUSINESS		CAUSE OF DEATH (List all causes, beginning with immediate cause, and giving date of onset of each)	
DECEASED'S ADDRESS (Street, city, state, zip) STREET, CITY, STATE, ZIP		DECEASED'S RACE WHITE NEGRO OTHER		DECEASED'S RELIGION METHODIST ROMAN CATHOLIC LUTHERAN OTHER		DECEASED'S EDUCATION GRADE SCHOOL HIGH SCHOOL COLLEGE		DECEASED'S MANNER OF DEATH SUICIDE ACCIDENTAL NATURAL CAUSE		DECEASED'S SOCIAL SECURITY NUMBER XXX-XX-XXXX		DECEASED'S MEDICAL HISTORY (List all diseases, conditions, and operations, beginning with the most recent)		DECEASED'S PRESENT ILLNESS (List all symptoms, signs, and tests, beginning with the onset of the illness)	
DECEASED'S DATE OF DEATH YEAR MONTH DAY		DECEASED'S TIME OF DEATH HOUR MINUTE		DECEASED'S PLACE OF DEATH HOME HOSPITAL OTHER		DECEASED'S SIGNATURE (Print name)		DECEASED'S SEX MALE FEMALE		DECEASED'S AGE YEARS MONTHS DAYS		DECEASED'S CAUSE OF DEATH (List all causes, beginning with immediate cause, and giving date of onset of each)		DECEASED'S MANNER OF DEATH SUICIDE ACCIDENTAL NATURAL CAUSE	
DECEASED'S ADDRESS (Street, city, state, zip) STREET, CITY, STATE, ZIP		DECEASED'S RACE WHITE NEGRO OTHER		DECEASED'S RELIGION METHODIST ROMAN CATHOLIC LUTHERAN OTHER		DECEASED'S EDUCATION GRADE SCHOOL HIGH SCHOOL COLLEGE		DECEASED'S MANNER OF DEATH SUICIDE ACCIDENTAL NATURAL CAUSE		DECEASED'S SOCIAL SECURITY NUMBER XXX-XX-XXXX		DECEASED'S MEDICAL HISTORY (List all diseases, conditions, and operations, beginning with the most recent)		DECEASED'S PRESENT ILLNESS (List all symptoms, signs, and tests, beginning with the onset of the illness)	

BUREAU V. 3

OCT 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11151

CERTIFICATE OF DEATH

11170

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Earl</u> Last <u>Witley</u>		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Witley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Harrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Magdalene Witley</u>		Address <u>St. Michaels</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated duodenum ulcer</u> 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>4:55 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>219 E. Washington St. 120457</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS <u>Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 14, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oliver Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hamberton Harrison</u>		ADDRESS <u>St. Michaels Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newmyer</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		RACE _____	
OCCUPATION _____		MARITAL STATUS _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		PLACE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

BUREAU V. S.

OCT 17 1957

RECEIVED

11152

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Mae</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>19 57</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>4</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Costley</u>		14. MOTHER'S MAIDEN NAME <u>Allice Mae Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Allice Mae Wilson (mother)</u>	
16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Possible hypoxia in the newborn</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/12/57</u> , 19 <u>57</u> , to <u>10/13/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/12/57</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		DATE SIGNED <u>10/13/57</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton 16 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>10/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springton</u>	22d. LOCATION (City, town, or county) (State) <u>Trappe, Md. R.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washell</u>		24a. REC'D BY REGISTRAR DATE <u>10/17/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>N.H. Neenan</u>	

CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the certificate form, including what appears to be a signature and various stamps.]

BUREAU V. 5

Oct 21 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11153

CERTIFICATE OF DEATH

Reg. Dist. No.

11172
290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> 05x0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Will</u> Middle <u>Wright</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24 1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Perry J Wright</u>				14. MOTHER'S MAIDEN NAME <u>Annie Winchester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Adeline Wright (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardi</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Vascular disease</u> DUE TO (c) <u>2 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)				
20c. TIME OF INJURY Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/4</u> , 19 <u>57</u> , to <u>10/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>57</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. C. Gof</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/13/57</u>		<u>Denton</u>		<u>Denton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais Greensboro Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Neenan</u>	

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